

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
00404													
00401													
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Greensboro						c. LENGTH OF STAY IN b 1 Yr.							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None						e. STREET ADDRESS None							
3. NAME OF DECEASED (Type or print) Eugene Russell Bell						4. DATE OF DEATH Month 1 Day 29 Year 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-21-1917		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James N. Bell						14. MOTHER'S MAIDEN NAME Lula E. Harrison							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 11						16. SOCIAL SECURITY NO. 186-01-1697						17. INFORMANT Norma Bell Greensboro, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY EMBOLUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO MYOCARDIAL INFARCT (1960) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH 5 MIN.													
21. I certify that (I) (this hospital) attended the deceased from 11-8-60 to 1-29-62 that (I) (we) last saw the deceased alive on 1-28-62 and that death occurred at 11:30A from the causes and on the date stated above.													
22a. SIGNATURE Robert H. Wright, M.D.						22b. DATE SIGNED 1-30-62							
22c. PHYSICIAN'S NAME (Type) ROBERT H. WRIGHT, M.D.						22d. ADDRESS GREENSBORO, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 2, 62		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulois Greensboro, Md.						25a. REC'D BY REGISTRAR FEB 1 '62		25b. REGISTRAR'S SIGNATURE Arthur L. House					

01150750

11-11-11

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00405		00402	
1. PLACE OF DEATH a. COUNTY Caroline <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro	
c. LENGTH OF STAY IN b. 55 Yrs.		d. STREET ADDRESS None	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Henry Bright		4. DATE OF DEATH Month 1 Day 1 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1906
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR: Months 1 Days 1 Hours 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Pet Milk Co.		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bright		14. MOTHER'S MAIDEN NAME Mary Stubbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 220-07-3592	
17. INFORMANT Anna Bright Goldsboro, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolus 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Thrombosis & Infarction (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 MIN 2 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-23 , 19 60 to 7-1 , 19 62 , that (I) (we) last saw the deceased alive on 1-1 , 19 62 , and that death occurred at 2 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert H. Wright</i> M.D.		22b. DATE SIGNED 1-3-62	
22c. PHYSICIAN'S NAME (Type) ROBERT H. WRIGHT M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-4-62	23c. NAME OF CEMETERY OR CREMATORY Greensboro	23d. LOCATION (City, town or county) (State) Greensboro, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulais</i>		25a. REC'D BY REGISTRAR DATE JAN 5 '62	
ADDRESS Greensboro, Md.		25b. REGISTRAR'S SIGNATURE <i>John S. Hanks</i>	

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Caroline

England

Caroline

James Goldsmith

52 Ave.

James Goldsmith

Home

Home

Robert

Robert

Robert

Dec. 6, 1908

John

John

London and N.Y. Co.

London and N.Y. Co.

John and Mary

John and Mary

220-7-222 and 222-7-222

Greenboro, Maryland

Greenboro

Greenboro

JAN 5 1909

John and Mary

TO HOSPITAL BE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00406

00403

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg, Md.	
c. LENGTH OF STAY IN lb 40 yrs.		d. STREET ADDRESS Preston Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Preston Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Claudel N. Bullock		4. DATE OF DEATH Jan. 3, 1962	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1919	
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic Service Trucking Co.	
11. BIRTHPLACE (County & State, or foreign country) Hurlock, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Bullock		14. MOTHER'S MAIDEN NAME Grace Lord	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-01-1745	
17. INFORMANT Mrs. Pearl Bullock		Address Federalsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 4-20-62 20 min 4 years		INTERVAL BETWEEN ONSET AND DEATH 20 min 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1960 to January 3, 1962 that (I) (we) last saw the deceased alive on January 3, 1962 , and that death occurred at 11.45 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Anderson M.D.		22b. DATE SIGNED Jan 10 '62	
22c. PHYSICIAN'S NAME (Type) Frank M. Anderson M.D.		22d. ADDRESS Federalsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1/6/62	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION (City, town or county) (State) Federalsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Wilkins		25a. REC'D BY REGISTRAR JAN 10 '62	
ADDRESS Federalsburg, Md.		25b. REGISTRAR'S SIGNATURE Robert L. Hume	

(M)

Certificates

Robert L. Brown, Jr.

Robert L. Brown, Jr.

Clarence M. Brown

White

April 13, 1913

John C. Brown Service Trucking Co. Norfolk, Va. U.S.A.

John C. Brown

Grace Lane

no 100-01-15-3 Mrs. Robert Brown, Norfolk, Va.

10 min.

Continued

Continued

January 13, 1913

1913

Robert L. Brown, Jr.

Robert L. Brown, Jr.

Robert L. Brown, Jr.

Robert L. Brown, Jr.

00407

CERTIFICATE OF DEATH

Reg. Dist. No. 1114114

1. PLACE OF DEATH o. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. LENGTH OF STAY IN 1b 40 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) ELIZABETH First CARRIE Middle CALLOWAY Last		4. DATE OF DEATH Month JAN Day 5 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 9 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY E SPARKS		14. MOTHER'S MAIDEN NAME DIGGINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Walter Calloway Address Denton Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic coronary atherosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic general atherosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 yr 7 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic allergic asthma 60 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 20 , 19 62 , to Jan 5 , 19 62 , that I last saw the deceased alive on January 5 , 19 62 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Paul Knotts		ADDRESS (Street, city or town, state) 406 Market St	
PHYSICIAN'S NAME (Type) E. Paul Knotts M.D.		DATE SIGNED Denton, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Jan. 8, 1962	Greenmount	Denton Md
23. FUNERAL DIRECTOR'S SIGNATURE Virgil Moore ADDRESS Denton Md		24a. REC'D BY REGISTRAR DATE JAN 15 '62	24b. REGISTRAR'S SIGNATURE E. Paul Knotts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
00408
00405
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 West Central Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hazel Middle Gompf Last Coleman		4. DATE OF DEATH Month January Day 17 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1917
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 44 Days 17 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Caroline Co. Schools	
11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clayton N. Gompf		14. MOTHER'S MAIDEN NAME Annie E. Bayne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 221-05-5207	
17. INFORMANT James F. Coleman, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-17-62 to 1-17-62 , that (I) (we) last saw the deceased alive on 1-17-62 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Anderson		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frank M. Anderson M.D.		22d. ADDRESS Federalsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 21, 1962	
23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR JAN 24 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hauer		25c. DATE	

(M)

2000

STATEMENT OF DEATH

DECEASED: [Name] [Address] [City] [State] [Zip]

DATE OF DEATH: [Date] TIME OF DEATH: [Time]

PLACE OF DEATH: [Location]

CAUSE OF DEATH: [Cause]

MANNER OF DEATH: [Manner]

DECEASED'S SIGNATURE: [Signature]

WITNESSES' SIGNATURES: [Signatures]

DECEASED'S AGE: [Age]

DECEASED'S SEX: [Sex]

DECEASED'S RACE: [Race]

DECEASED'S RELIGION: [Religion]

DECEASED'S OCCUPATION: [Occupation]

DECEASED'S MARITAL STATUS: [Status]

DECEASED'S EDUCATION: [Education]

DECEASED'S BIRTH DATE: [Date]

DECEASED'S BIRTH PLACE: [Place]

DECEASED'S BIRTH TIME: [Time]

DECEASED'S BIRTH WEIGHT: [Weight]

DECEASED'S BIRTH LENGTH: [Length]

DECEASED'S BIRTH HEAD CIRCUMFERENCE: [Circumference]

DECEASED'S BIRTH SKIN COLOR: [Color]

DECEASED'S BIRTH HAIR COLOR: [Color]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00406

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DENTON</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Burrsville</u>		2. USUAL RESIDENCE (When deceased lived in institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burrsville</u> d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM JACOB ENSLEN</u> First Middle Last 4. DATE OF DEATH <u>Jan. 25 1962</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>DEC 8 1896</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Single 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST RETARD</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>WILLIAM ENSLEN</u> 14. MOTHER'S MAIDEN NAME <u>LOUISE MILLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW1</u> 16. SOCIAL SECURITY NO. <u>146-32-3858</u> 17. INFORMANT <u>Mrs. Constance Enslen, Denton, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Jan. 25 - 1962</u>			
ACTUAL SIGNATURE <u>Dawson O. George</u> EXAMINER'S NAME (Type) <u>Dawson O. George, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Jan 27 1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW</u> 22d. LOCATION (City, town, or country) (State) <u>CLEVELAND Ohio</u>		23. FUNERAL DIRECTOR <u>J. V. and Moore & Son Denton, Md.</u> ADDRESS 24a. REC'D BY REGISTRAR <u>JAN 30 '62</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

FOR MAIL
POSTAGE PAID



MAILED AT DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
No. 1000
Name of Deceased
Age
Sex
Race
Color
Date of Death
Place of Death
Cause of Death
Manner of Death
Signature of Medical Examiner
Signature of Coroner
Signature of Registrar

CERTIFICATE OF DEATH

Reg. Dist. No. 004107

00410

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>EDWARD</u> Middle <u>LISTER</u> Last				4. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 22, 1892</u>	9. AGE (In years last birthday) yrs. <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH LISTER</u>				14. MOTHER'S MAIDEN NAME <u>MARY V. HENRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>MRS. JOHN LISTER, DENTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 Coronary Occlusion</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 16, 1956</u> to <u>Jan 13, 1962</u> ; that I last saw the deceased alive on <u>Jan 12, 1962</u> ; and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Denton, Maryland</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Lawson O. George</u> M.D.				PHYSICIAN'S NAME (Type) <u>Lawson O. George, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 16, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>		22d. LOCATION (City, town, or county) (State) <u>DENTON, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>IRVING MOORE & SON, DENTON, MD</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00411														
CERTIFICATE OF DEATH														
01408														
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel					c. LENGTH OF STAY IN Yr 69 Yrs.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel									
					d. STREET ADDRESS None									
3. NAME OF DECEASED (Type or print) Nathan Henry Marvel					4. DATE OF DEATH Month 1 Day 20 Year 19 62									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1892		9. AGE (In years last birthday) 69 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Phillip A. Marvel					14. MOTHER'S MAIDEN NAME Mollie E. Moore									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 215-36-2427					17. INFORMANT Lula Marvel Marydel, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Generalized Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from July 12, 1961 , to Jan. 20, 1962 that (I) (we) last saw the deceased alive on Jan. 19, 1962 , and that death occurred at 11 M, from the causes and on the date stated above.														
22a. SIGNATURE Charles H. Stonesifer M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 1-22-62									
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.					22d. ADDRESS Greensboro, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-23-62									
23c. NAME OF CEMETERY OR CREMATORY Greensboro					23d. LOCATION (City, town or county) (State) Greensboro, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE J.E. Boulais					ADDRESS Greensboro, Md.									
25a. REC'D BY REGISTRAR DATE JAN 25 '62					25b. REGISTRAR'S SIGNATURE Arthur L. Hines									

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00413

00410

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Ridgely				c. LENGTH OF STAY IN 1b 77 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None				e. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Mary Middle Adeline Last Thomas				4. DATE OF DEATH Month 1 Day 9 Year 19 62			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Freeman				14. MOTHER'S MAIDEN NAME Martha Heins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lillian Stanford Wilmington, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Dis. with hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1962 to Jan. 9, 1962 , that (I) (we) last saw the deceased alive on Jan. 9, 1962 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles H. Stonesifer</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-12-62	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer				22d. ADDRESS Greensboro, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-62		23c. NAME OF CEMETERY OR CREMATORY Thomas Burial Ground		23d. LOCATION (City, town or county) (State) Ridgely, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Bouclair</i>				ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 '62	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>			

(M)

1961

Caroline

Carol, Mary

John

John

Col. John

Caroline

Alfred, Robert

one

Caroline, Robert

Autism, autistic disorder, etc.
with hypochondria

Jan. 2, 62

Jan. 1, 62 Jan. 2, 62

1-1-62

Charles H. Stoner, Jr.

1-1-62

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00411

00414

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg- Rural	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg- Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Federalsburg		d. STREET ADDRESS Near Federalsburg	
3. NAME OF DECEASED (Type or print) First James Middle Michael Last Todd		4. DATE OF DEATH Month January Day 3 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1961
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Kemp Todd, Jr.		14. MOTHER'S MAIDEN NAME Dorothy E. Marine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT J. Kemp Todd, Jr.		Address Federalsburg, Md. R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Viral pneumonia - over underlying infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 8 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9.14.61 to 1.3 19 62 that (I) (we) last saw the deceased alive on 12-29 19 61 , and that death occurred at 9AM , from the causes and on the date stated above.			
22a. SIGNATURE H. R. Trapnell		22b. ADDRESS Federalsburg, Maryland	
22c. PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D.		22d. ADDRESS Federalsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 5, 1962	23c. NAME OF CEMETERY OR CREMATORY Hill Crest	23d. LOCATION (City, town, or county) (State) Federalsburg Maryland
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Md.		25a. REC'D BY REGISTRAR DATE JAN 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE JAN 8 '62	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00415

00412

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Avenue				d. STREET ADDRESS Maple Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Jefferson Last Williams				4. DATE OF DEATH Month January Day 15 Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1899	
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station Operator (Gasoline)				10b. KIND OF BUSINESS OR INDUSTRY Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Williams				14. MOTHER'S MAIDEN NAME Dollie Toulson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-01-1204		17. INFORMANT Mrs. Blanche V. Williams, Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO 1 day (c) 7							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 15, 1962 to January 15, 1962 that (I) (we) last saw the deceased alive on Jan 15 1962 and that death occurred at 10:20 PM from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/19/62			
22c. PHYSICIAN'S NAME (Type) G. Metzler, Jr. M.D.		22d. ADDRESS Bridgeton Delaware					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 18, 1962		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR JAN 24 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-10-15

CERTIFICATE OF DEATH

11-10-15

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11-10-15

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11-10-15

11-10-15